DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 8

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.70

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 367,800
b. FFY 2002 $ 367,800

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A Pages 7.3.1,7.3.1(a), 7.3.2
Attachment 3.1-B pagee 24,24.1,25
Attachment 4.19-Bpages 20/13-A, 20.14

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SAME

10. SUBJECT OF AMENDMENT:
Reimbursement Methodology for Durable Medical Equipment

11. GOVERNOR'S REVIEW *(Check One)*:

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Review delegated to Commissioner Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[signature]

13. TYPED NAME:
Dennis Boyd

14. TITLE:
Commissioner Dept For Medicaid Services

15. DATE SUBMITTED:
5/11/01

16. RETURN TO:
Sharon A. Rodriguez, Manger
Policy Coordination Branch
Department for Medicaid Services
275 East Main Street 6EA
Frankfort KY 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
May 15, 2001

18. DATE APPROVED:
June 14, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:
[signature]

21. TYPED NAME:
Eugene A. Granger

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

7. Home Health Care Services

7.a. Intermittent or Part-Time Nursing Service

1. There are no limitations on the intermittent or part-time nursing service provided by the home health agency.

2. There are no limitations on the intermittent or part-time nursing service provided by the registered nurse when no home health agency exists in the area except that the registered nurse must be approved by the local health department serving that area as capable of performing the service.

3. Home health agencies may provide disposable medical supplies necessary for, or related to, the provision of intermittent or part-time nursing service as specified for coverage by the Medicaid Program.

7.c. Medical Supplies, Equipment, Prosthetics, and Orthotics Suitable for Use in the Home

Each provider desiring to participate as a durable medical equipment, prosthetic, orthotic, or medical supply provider must be a participating Medicare provider and sign a provider agreement with the Department for Medicaid Services.

Durable medical equipment, prosthetics, orthotics, and medical supplies are covered only in accordance with the following conditions:

1. The Department covers items specified in the Medicare Region C DMERC DMEPOS Suppliers Manual. The provider may, however, submit requests for other specific items not covered by Medicare or not routinely covered by the Medicaid Program for consideration.

The provider submits a certificate of medical necessity (CMN) and, if required, a prior authorization form and any other documentation to support medical necessity. Unless specifically exempted by the Department, DME items, supplies, prosthetics, and orthotics will require a CMN completed by the prescriber that will be used by the department to document medical necessity.

2. Coverage of durable medical equipment and supplies, prosthetics, and orthotics for use of patients in the home is based on medical necessity and the requirements of 42 CFR 440.230(c).

   Coverage criteria established by the Medicare program will be used as a guide in determining medical necessity but will be subject to a medical necessity override.

3. The criteria used in the determination of medical necessity includes an assessment of whether the item is:

   a. Provided in accordance with 42 CFR 440.230;
   b. Reasonable and required to identify, diagnose, treat, correct, cure, ameliorate, palliate, or prevent a disease, illness, injury, disability, or other medical condition.
   c. Clinically appropriate in terms of amount, scope, and duration based on generally accepted standards of good medical practice;
   d. Provided for medical reasons rather than primarily for the convenience of the recipient, caregiver, or the provider.
   e. Provided in the most appropriate location, with regard to generally accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;
   f. Needed, if used in reference to an emergency medical service, to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; and,
   g. Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 USC 1396d(r) and 42 CFR 441 Subpart B, for recipients under twenty-one (21) years of age.

4. An item of durable medical equipment, prosthetic, or orthotic shall be durable in nature and able to stand repeated use. Coverage of an item of durable medical equipment, prosthetic, orthotic, or medical supply shall be in accordance with the following: shall serve a medical purpose; shall not generally be useful to a person in the absence of illness or injury; shall be appropriate for use in the home; and shall be medically necessary, and reasonable.

5. The following general types of durable medical equipment, prosthetics or orthotics are excluded from coverage under the durable medical equipment program:

   a. Items which would appropriately be considered for coverage only through other sections of the Medicaid Program, such as frames and lenses, hearing aids, and pacemakers;
   b. Items which are primarily and customarily used for a non-medical purpose, such as air conditioners and room heaters;
   c. Physical fitness equipment, such as exercycles and treadmills; and,
   d. Items which basically serve a comfort or convenience function or which are primarily for convenience of the recipient or the person caring for the recipient, such as elevators and stairway elevators.

7.d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility

1. Audiology services are not provided under this component.

2. Physical therapy, occupational therapy, or speech pathology services provided by a medical rehabilitation facility are not provided under this component.

9. Clinic Services

Coverage for clinic services is limited to services provided by the following clinics and includes:

1. Mental health centers licensed in accordance with applicable state laws and regulations. However, services rendered by community mental health centers to skilled nursing or intermediate care facility patients/residents are not covered.
2. Family planning clinics.
3. Clinics engaging in screening for the purposes of the early and periodic screening, diagnosis, and treatment component of the Medicaid Program.
4. Outpatient surgical clinics.
5. Other clinics authorized under 42 CFR 440.90.

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2. There are no limitations on the intermittent or part-time nursing service provided by the registered nurse when no home health agency exists in the area except that the registered nurse must be approved by the local health department serving that area as capable of performing the service.

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   c. Clinically appropriate in terms of amount, scope, and duration based on generally accepted standards of good medical practice;
   d. Provided for medical reasons rather than primarily for the convenience of the recipient, caregiver, or the provider.
   e. Provided in the most appropriate location, with regard to generally accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;
   f. Needed, if used in reference to an emergency medical service, to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; and,
   g. Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 USC 1396d(r) and 42 CFR 441 Subpart B, for recipients under twenty-one (21) years of age.

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annual cost report data with costs trended through June 30 and indexed for the rate year; the rate year shall begin on July 1, and end on June 30; and the upper limit shall be subject to an annual adjustment to be effective on July 1 of each rate year. Aggregation of costs (i.e., shifting of allowable costs from one cost center to another if the limit is exceeded in one cost center but not in another) will be permitted. The array shall be based on the latest available cost report as of May 31 preceding the rate year.

A home health agency will be reimbursed for durable medical equipment (DME), prosthetics, or orthotics only if the agency signs a DME provider participation agreement.

The agency will continue to be reimbursed for disposable medical supplies without regard to whether the agency participates as a DME provider. Disposable medical supplies shall be reimbursed on an interim basis at a percent of allowable billed charges with a settlement to actual cost at the end of the agency's fiscal year.

New home health agencies shall be paid seventy (70) percent of the Title XIX maximum rate not to exceed Medicare upper limits until a fiscal year end cost report is available.

Provider taxes shall be considered allowable costs; for the rate period beginning on July 1, 1993 and ending on June 30, 1994, the cost of the provider tax shall be added to the rate as an add-on. For subsequent rate periods, the provider tax cost shall be shown in the appropriate cost report used for rate-setting.

B. Out-of-State Home Health Agencies

The Cabinet shall reimburse participating out-of-state home health agencies at the lower of the Title XVIII maximum payment rate, the Title XIX maximum payment rate or the agency's usual and customary actual billed charge. For these out-of-state agencies, disposable medical supplies shall be reimbursed at a rate of eighty (80) percent of the usual and customary actual billed charge.

(2) Limitations of Allowable Cost

A. Owner's Compensation Limits

Compensation to owners will be considered an allowable cost provided that it is reasonable and that the services actually performed are a necessary function.

An owner, for the purposes of the payment system, is defined as any person and related family member (as specified below) with a cumulative ownership interest of 5 percent or more. Members of the immediate family of an owner, including husband, wife, father, mother, brothers, sisters, sons, daughters, aunts, uncles, and in-laws, will be treated as owners for the purpose of compensation.

XIV. Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies

1. Participating providers will be reimbursed at the lessor of the Medicare rate published in the Medicare Fee Schedule (including manually priced items) or the supplier's usual and customary price for items for which there is a Medicare-reimbursable HCPCS code. If there is not a Medicare-reimbursable HCPCS code for an item, Medicaid will reimburse the maximum allowable amount for the item on the current Kentucky Medicaid DME Fee Schedule, if applicable, or the lessor of acquisition cost plus thirty (30) percent or the supplier's usual and customary price.

2. Reimbursement will be made for the following, as appropriate: the Medicaid fee schedule amount for the purchase or rental of an item of durable equipment, prosthetic, or orthotic; reasonable repairs; and extensive maintenance to purchased equipment if recommended by the manufacturer and performed by an authorized technician. The total monthly rental reimbursement shall not exceed the retail price.

3. Deductible and coinsurance payments will be based on the allowable charges as determined by the Title XVIII program.